STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	005113	A. BUILDING: _____ B. WING _____	09/11/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
KOSCIUSKO COMMUNITY HOSPITAL	2101 E DUBOIS DR WARSAW, IN 46580

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S 000	INITIAL COMMENTS The visit was for investigation of a State hospital complaint. Complaint Number: IN 00153481 Unsubstantiated: Lack of sufficient evidence. Date: 9-11-14 Facility Number: 005113 Surveyor: Brian Montgomery, RN, BSN Public Health Nurse Surveyor Kosciusko Community Hospital is in compliance with 410 IAC 15-1.5-5, Medical Staff and 410 IAC 15-1.6-2, Emergency Services, Indiana Hospital Licensure Rules. QA: claughlin 09/24/14	S 000		